Distribution:
White : Court
Yellow: Insurer
Pink: Employer
Golden: Employee

State of Rhode Island and Providence Plantations

PROVIDENCE, SC

WORKERS' COMPENSATION COURT

Employee - Petitioner

W.C.C. No.

Social Security Number

Name of Employer - Respondent

Address of Employer - Respondent

Name of Agent for Service of Process

Insurance Carrier

Address of Agent for Service of Process

Employee's Petition to Review and/or Amend Agreement or Decree Concerning Compensation

The undersigned EMPLOYEE hereby petitions for a determination of my right to benefits under a compensation agreement, or under a decree of the Workers' Compensation Court. A TRUE COPY OF SAID AGREEMENT OR DECREE IS FILED HEREWITH. In support of my petition, I affirm that the following facts are true:

☐ 1. My incapacity for work has increased or returned by reason of the effects of the injury set forth in said agreement decree:
Total incapacity from to
Partial incapacity from to

☐ 2. My employer refuses to provide or pay for necessary medical services, etc., as provided by General Laws, 1956, Sec. 28-33-5 and 28-33-8.

☐ 3. My employer and/or its insurance carrier refuse to give written permission for major surgery, Specifically:_____.
(Attach a copy of doctor's request for surgery)

☐ 4. Weekly payments of compensation have been based on erroneous average weekly wage. My average weekly wage at the time of my injury was $_____.

☐ 5. The compensation agreement or decree was procured by fraud, coercion or mutual mistake of fact.

☐ 6. The compensation agreement or decree does not accurately and completely set forth and describe the nature and location of all injuries sustained by me. Said agreement or decree should be amended so that the nature and location of my injuries would read as follows:

☐ 7. Per R.I.G.L. Sec. 28-33-18.3 I have received a notice of intention to terminate partial incapacity benefits pursuant to R.I.G.L. Sec. 28-33-18(d), and I hereby petition the court for continuation of benefits.

☐ 8. Per R.I.G.L. Sec. 28-33-47 and the W.C.C. Rules of Practice, I hereby petition the court for a Rehabilitation Program Approval

☐ 9. Per R.I.G.L. Sec. 28-33-47 and the W.C.C. Rules of Practice, I hereby petition the court for my right of Reinstatement.

☐ 10. Other:

Attorney Name	Attorney Signature	Signature of Employee
Attorney Address	Date	Employee's Address
Attorney City, State, Zip Code	Attorney Registration No.	Employee's City, State, Zip Code

File original, employer and insurer copies with Administrator of Workers' Compensation Court, J. Joseph Garrahy Judicial Complex, One Dorrance Plaza, Providence, RI 02903-3973. Attach three extra copies of the preliminary agreement or decree fixing compensation. If the original agreement or decree has been modified, attach copies of the latest modifications.

WCC 9 (Rev 1102)